
**Medicare
Carriers Manual**

Department of Health and
Human Services (DHHS)
HEALTH CARE FINANCING
ADMINISTRATION (HCFA)

Part 3 - Claims Process

Transmittal 1670

Date: JULY 13, 2000

CHANGE REQUEST 1211

<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
Table of Contents - Chapter XV	15-1 - 15-2 (2 pp.)	15-1 - 15-2 (2 pp.)
15360 - 15501 (Cont.)	15-73 - 15-74 (2 pp.)	15-73 - 15-74 (2 pp.)

**NEW/REVISED MATERIAL--*EFFECTIVE DATE:* October 1, 2000
IMPLEMENTATION DATE: October 1, 2000**

Section 15360, Echocardiography Services (Codes 93303 - 93350), is added to advise carriers of a new HCPCS Level II Code for contrast agents used in echocardiography. The contrast agent is separately payable. The new code is Q0188. The type of service code is 9. The code will be carrier-priced.

Q0188 SUPPLY OF INJECTABLE CONTRAST MATERIAL FOR USE IN
ECHOCARDIOGRAPHY, PER STUDY.

These instructions should be implemented within your current operating budget.

CHAPTER XV

FEE SCHEDULE FOR PHYSICIANS' SERVICES

	<u>Section</u>
Fee Schedule for Physicians' Services	15000
Physicians' Services Paid Under Fee Schedule	15002
Entities/Suppliers Whose Physicians' Services Are Paid for Under Fee Schedule.....	15004
Method for Computing Fee Schedule Amount	15006
Transition Payments.....	15008
Bundled Services/Supplies.....	15010
Payment Localities	15012
Services of Physicians Furnished in Providers or to Provider Patients	15014
Supervising Physicians in Teaching Setting	15016
Payment Conditions for Anesthesiology Services	15018
Payment Conditions for Pathology Services	15020
Payment Conditions for Radiology Services	15022
Interpretation of Diagnostic Tests.....	15023
Summary of Adjustments to Fee Schedule Computations.....	15024
Unusual Travel	15026
Unusual Circumstances.....	15028
Supplies.	15030
Participating Versus Nonparticipating Physician Differential.....	15032
Payment Reduction for Certain Services Performed in Hospital Outpatient	
Departments and Ambulatory Surgical Centers.....	15036
Multiple Surgeries	15038
Bilateral Surgery.	15040
General.	15040.1
Bilateral Surgery Indicators	15040.2
Assistant at Surgery Services	15044
Co-Surgeons/Surgical Team.....	15046
Purchased Diagnostic Tests.....	15048
Allergy Testing and Immunotherapy.....	15050
HPSA Bonus Payments.....	15052
No Adjustments.	15054
Multiple Adjustments.....	15056
Update Factor for Fee Schedule Services	15058
Monthly Capitation Payment Method for Physicians' Services Furnished to	
Patients on Maintenance Dialysis	15060
Services Included and Excluded From Monthly Capitation Payment	15060.1
Billing and Payment Procedures	15060.2
Determining Monthly Capitation Payment for Physician's Services to	
Maintenance Dialysis Patients	15060.3
Temporary Absence	15060.4
Physician's Self-Dialysis Training Services.....	15060.5
Daily Visit Charges for Inpatient Hospital Visits	15062
Payment for Physicians' Services Furnished to Dialysis Inpatients.....	15062.1
Comparability of Payment Provision of Delegation of Authority by	
HCFA to Railroad Retirement Board.....	15064
Fee Schedule Payment for Services to Homebound Patients Under General Supervision.....	15066
Correct Coding Policy.....	15068
Integumentary System.....	15070
Digestive System	15100

CHAPTER XV

	<u>Section</u>
Urinary and Male Genital Systems	15200
Otolaryngology and Audiology/Speech/Language Tests and Treatments	15300
Dialysis Services.....	15350
Echocardiography Services	15360
Chemotherapy Administration.....	15400
Evaluation and Management Service Codes - General.....	15501
Payment for Evaluation and Management Services Provided During	
Global Period of Surgery.....	15501.1
Payment for Office/Outpatient Visits.....	15502
Payment for Hospital Observation Services.....	15504
Payment for Inpatient Hospital Visits – General.....	15505
Payment for Initial Hospital Care Services.....	15505.1
Subsequent Hospital Visit and Hospital Discharge Management.....	15505.2
Consultations	15506
Emergency Department Visits	15507
Critical Care Visits and Neonatal Intensive Care	1 5508
Nursing Facility Visits	15509
Home Care and Domiciliary Care Visits	15510
Prolonged Services and Standby Services	15511
Prolonged Services.....	15511.1
Prolonged Services Without Face to Face Service.....	15511.2
Physician Standby Service.....	15511.3
Case Management Services	15512
Care Plan Oversight (CPO) Services	15513
Preventive Medicine Services (Excluding Immunizations), Newborn Services, and Other Evaluation and Management Services	15514
Home Services.....	15515
Medicare Physician Fee Schedule Database (MPFSDB) 1999 File Layout	15900
MPFSDB Status Indicators	15901
Maintenance Process for the Medicare Physician Fee Schedule Database (MPFSDB).....	15902
Appendix A - 1998 Geographic Practice Cost Indices by Medicare Carrier and Locality	

15360. ECHOCARDIOGRAPHY SERVICES (CODES 93303 - 93350)

Separate Payment for Contrast Media. -- Effective October 1, 2000, physicians may separately bill for contrast agents used in echocardiography. Physicians should use HCPCS Code Q0188 (Supply of injectable contrast material for use in echocardiography, per study). The type of service code is 9. This code will be carrier-priced.

15400. CHEMOTHERAPY ADMINISTRATION (CODES 96400-96549)

A. General Use of Codes.--Chemotherapy administration codes, 96400 through 96450, 96542, 96545, and 96549, are only to be used when reporting chemotherapy administration when the drug being used is an antineoplastic and the diagnosis is cancer. The administration of other drugs, such as growth factors, saline, and diuretics, to patients with cancer, or the administration of antineoplastics to patients with a diagnosis other than cancer, are reported with codes 90780 through 90784 as appropriate.

B. Chemotherapy Administration By Push and Infusion On Same Day.--Separate payment is allowed for chemotherapy administration by push and by infusion technique on the same day. Allow only one push administration on a single day.

C. Chemotherapy Infusion and Hydration Therapy Infusion On Same Day.--Separate payment is not allowed for the infusion of saline, an antiemetic, or any other nonchemotherapy drug under CPT codes 90780 and 90781 when administered at the same time as chemotherapy infusion (CPT codes 96410, 96412, or 96414). Separate payment is allowed for these two services on the same day when they are provided sequentially, rather than at the same time. Physicians use the modifier -GB to indicate when CPT codes 90780 and 90781 are provided sequentially with CPT codes 96410, 96412, and 96414.

D. Chemotherapy Administration and "Incident To" Services on Same Day.--On days when a patient receives chemotherapy administration but the physician has no face-to-face contact with the patient, the physician may report and be paid for "incident to" services furnished by one of the physician's employees, in addition to the chemotherapy administration, if they are furnished under direct personal supervision in the office by one of the physician's employees and the medical records reflect the physician's active participation in and management of the course of treatment. The correct code for this service is 99211.

E. Flushing Of Vascular Access Port.--Flushing of a vascular access port prior to administration of chemotherapy is integral to the chemotherapy administration and is not separately billable. If a special visit is made to a physician's office just for the port flushing, code 99211, brief office visit, should be used. Code 96530, refilling and maintenance of implantable pump or reservoir, while a payable service, should not be used to report port flushing.

F. Chemotherapy Administration and Hydration Therapy.--Do not pay separately for the infusion of saline, an antiemetic, or any other nonchemotherapy drug under codes 90780 and 90781 when these drugs are administered at the same time as chemotherapy infusion, codes 96410, 96412, or 96414. However, pay for the infusion of saline, antiemetics, or other nonchemotherapy drugs under codes 90780 and 90781 when these drugs are administered on the same day but sequentially to rather than at the same time as chemotherapy infusion, codes 96410, 96412, and 96414. Physicians should use modifier GB to indicate when codes 90780 and 90781 are provided sequentially rather than contemporaneously with codes 96410, 96412, and 96414. Both the chemotherapy and the nonchemotherapy drugs are payable regardless of whether they are administered sequentially or contemporaneously.

15501. EVALUATION AND MANAGEMENT SERVICE CODES - GENERAL (CODES 99201-99499)

A. Use Of CPT Codes.--Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.

B. Selection of Level Of Evaluation and Management Service.--Instruct physicians to select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection C.

C. Selection Of Level Of Evaluation and Management Service Based On Duration Of Coordination Of Care and/or Counseling.--Advise physicians that when counseling and/or coordination of care dominates (more than 50%) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. The code selection is based on the total time of the face-to-face encounter or floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code if time is the basis for selection of the code.

In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face to face physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided.

In an inpatient setting, the counseling and/or coordination of care must be provided at the bedside or on the patient's hospital floor or unit that is associated with an individual patient. Time spent counseling the patient or coordinating the patient's care after the patient has left the office or the physician has left the patient's floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.

D. Use Of Highest Levels Of Evaluation and Management Codes.--Advise physicians that to bill the highest levels of visit and consultation codes, the services furnished must meet the definition of the code (e.g., to bill a level 5 new patient visit, the history must meet CPT's definition of a comprehensive history).

The comprehensive history must include a review of all the systems and a complete past (medical and surgical) family and social history obtained at that visit. In the case of an established patient, it is acceptable for a

